# CONNECTICUT WOMEN'S HEALTH CAMPAIGN

**c/o Permanent Commission on the Status of Women**
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw


**The Connecticut Women's Health Campaign**

American Cancer Society
American Heart Association
Carey Consulting
Child Health Data Center
CT Association for Human Services
CT Breast Cancer Coalition
CT Chapter of American College of Nurse-Midwives
CT Citizens' Action Group
CT Coalition Against Domestic Violence
CT Coalition for Choice
CT Community Care, Inc.
CT NARAL
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CT Sexual Assault Crisis Services
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Department of Nursing Quinnipiac University
Dept. of Services for Persons with Disabilities, City of New Haven
Hartford College for Women
National Council of Jewish Women
Latino and Puerto Rican Affairs Commission
National Ovarian Cancer Coalition-CT
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# Briefing Papers on Women's Health March 2002

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## 2002 Legislative Priorities

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The following four issues represent top priorities that the Connecticut Women's Health Campaign will advocate during the 2002 legislative session. Following these, we also list other important issues that will improve women's health and will be addressed by member organizations.

### 1. Expand Access to Health Insurance Coverage for Uninsured Adults

- Expand eligibility for HUSKY to adults up to 300% of poverty
- Permit small businesses to purchase health insurance through a plan similar to that currently offered to municipalities and some non-profits through the Comptroller's office

### 2. Reduce Smoking Among Women and Girls in Connecticut

- Require Medicaid coverage for smoking cessation treatment and programs
- Increase cigarette tax and use revenue for public health purposes, including smoking prevention and treatment programs and health care for uninsured
- Increase use of tobacco settlement funds for tobacco use prevention programs, including programs that are targeted for women and girls

### 3. Make Prescription Medications More Affordable and Accessible

- Implement ConnPACE B program and expand eligibility to all uninsured adults
- Develop purchasing strategies that allow individuals to obtain medications at discounted rates comparable to those available to government purchasers

### 4. Restore Funding for all Medical Transportation for SAGA Recipients

## Additional Important Actions to Improve Women's Health

### Improve Services to Victims of Violence

- Support increased appropriation for "Through Any Door" program for public education and coordination of services to victims of violent crime

### Protect Access to Reproductive Health Care for Women

- Protect or strengthen Certificate of Need authority to prevent hospital or other health care actions which result in reduced access to the full range of reproductive health care services

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- Protect a woman's right to choose and to access to complete and accurate information about reproductive health care

### Restore Funding for Primary Care Case Management Pilot Project and Explore Alternatives to Medicaid Managed Care

### Continue Health Benefits for Legal Immigrants

### Restore Full Funding for the Office of Multicultural Health

### Increase Access to Quality Community Care for Older Women and Women with Disabilities to Prevent Unnecessary or Premature Institutionalization

- Support pre-admission screening for all elders prior to entering a nursing home to provide options to institutionalized care.
- Improve staff recruitment, education, compensation and retention through support of Long-Term Care Advisory Council initiatives.
- Keep full state funding for CT Home Care Program for Elders.

### Consumers' Rights and Medical Privacy

- Support health care reforms which protect patients' right to choose providers, receive medically necessary care without restrictions, and maintain privacy of medical records

### Health Care for Women with Disabilities

- Increase access of women with disabilities to health care services, particularly reproductive health care and screening services such as mammograms and pap tests

### Teen Pregnancy Prevention and Teen Parent Education

### Women with HIV/AIDS

- Support funding and other initiatives to increase access to treatment for women with HIV / AIDS and prevention services for all women and women at risk

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# Smoking Prevention and Cessation for Women and Girls

The CWHC supports increased state spending on programs to prevent and treat tobacco addiction in women and girls in Connecticut. Smoking is the leading known cause of preventable death and disease among women. "Women and Smoking: A Report of the Surgeon General" makes clear that smoking is a women's issue. The report concludes that we must act now to stop the marketing of cigarettes and other tobacco products to women and end the epidemic of smoking and smoking-related diseases among girls and women.

In spite of the fact that Connecticut has received $130 million since 1999 from the tobacco settlement, almost NO funds have been spent on direct prevention programs to date. On the other hand, the state has annual Medicaid expenditures for tobacco related illnesses of $181.7 million, and the total yearly health costs from tobacco in Connecticut are $1.2 billion.[1]

Despite increased knowledge of the adverse health effects of smoking during pregnancy, estimates of women smoking during pregnancy range from 13 percent to as high as 22 percent. "For every dollar invested in smoking cessation for pregnant women, about $6 is saved in neonatal intensive care costs and long-term care associated with low-birthweight deliveries."[2]

## What Needs to Be Done?

The Connecticut Women's Health Campaign supports a 3-prong solution to this problem:

1. Require Medicaid coverage for smoking cessation treatment and programs.
2. Use revenue from the cigarette tax increase for public health purposes, especially smoking prevention and treatment programs and health care for the uninsured.
3. Increase use of tobacco settlement funds for tobacco-use prevention programs, including programs that are targeted for women and girls.

### Some facts about women and smoking:

25.1% of women in prime child-bearing years (18-34) are smokers.[3] Smoking during pregnancy by teens continued to rise in 1999; over 12 percent of births to smokers were low-birthweight babies, compared to 7.2 percent of nonsmokers.[4]

Women who smoke during pregnancy subject themselves and their developing fetus and newborn to special risks, including pregnancy complications, premature birth, low-birthweight infants, stillbirth, and infant mortality.[5] The annual average number of deaths among Connecticut women related to smoking (years 1990-1994) was 2,057.[6]

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"In 1987, lung cancer surpassed breast cancer as the number one cause of cancer deaths among women. Between 1960 and 1990, the death rate from lung cancer among women increased by more than 400%, and the rate is continuing to increase."[7]

## For additional information, contact:

American Legacy Foundation, "Great Start" Program.
National Maternal and Child Health Clearinghouse - Counseling Women Who Smoke; Counseling from the Heart; If you Smoke and Are Pregnant www.nmchc.org/html/new.htm

MATCH (Mobilize Against Tobacco for Children's Health)
776 Farmington Avenue
West Hartford, CT 06119
860-586-8820
Fax 860-586-8834
www.matchcoalition.com

CT Department of Public Health
Tobacco Use Prevention & Control
and Health Education and Intervention
410 Capitol Avenue
Hartford, CT 06134
860-509-7802
Fax 860-509-7854
www.dph.state.ct.us.com

American Lung Association of CT, Inc.
45 Ash Street
East Hartford, CT 06108
860-289-540l
Fax 860-289-5405
www.alact.org.com

American Heart Association
5 Brookside Drive
Wallingford, CT 06492
203-294-0088
Fax 203-294-3577
http://women.americanheart.org

American Cancer Society
P.O. Box 410
Wallingford, CT 06492
1-800-ACS-2345
Fax 203-265-0281
www.cancer.org

**Endnotes**

1 Campaign for Tobacco-Free Kids, National Center for Tobacco-Free Kids, March 20, 2001, www.tobaccofreekids.org.
2 Facts on Women and Tobacco, Surgeon General's Report, Center for Disease Control, March 27, 2001, www.cdc.gov/tobacco.
3 Surgeon General's Report, 2001
4 Mathews TJ. Smoking During Pregnancy in the 1990s. National vital statistics reports. Vol 49 no 7. Hyattsville, Maryland: National Center for Health Statistics.
5 Facts on Women and Tobacco, Surgeon General's Report, Center for Disease Control, March 27, 2001, www.cdc.gov/tobacco.
6 *ibid.*
7 *ibid.*

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# Women and Cardiovascular Disease

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Coronary heart disease, which causes heart attack, is the leading cause of death for American women. Nearly twice as many women in the United States die of heart disease and stroke as from all forms of cancer, includ ing breast cancer. Unfortunately, women and health care providers do not always recognize the signs of heart disease among women nor do they take the steps they could to control risk factors and prevent the disease.

The American Heart Association has identified several factors that increase the risk of heart disease and stroke. The more risk factors a woman has, the greater the chance that she will have a heart attack or stroke. Some of these cannot be controlled, such as increasing age, family health history, and race and gender. But others can be modified, treated or controlled to lower the risk.

## What needs to be done?

- The state should fully fund smoking prevention and cessation programs and make sure they provide gender-specific programs for women and girls;
- The Department of Public Health, city and town health departments, schools and other appropriate agencies should work with providers, hospitals and non-profit agencies to expand our public education and outreach efforts in Connecticut about women and heart disease.

## What are the risk factors for heart disease and stroke?

**Increasing age -** The chances of developing heart disease increase as women grow older. As women approach the age of menopause, their risk of heart disease and stroke begins to rise and keeps rising with age. The loss of natural estrogen as women age may contribute to this higher risk after menopause.

**Sex (Gender) -** Men have a greater risk of heart attack than women, and they have attacks earlier in life. Overall, the incidence and prevalence of stroke are about equal for men and women. However, more than half of total stroke deaths occur in women.

**Heredity (family history) -** Both women and men are more likely to develop heart disease or stroke if their close blood relatives have had them. Race is also a factor. Black women have a greater risk of heart disease and stroke than white women, in large part because African Americans have higher average blood pressure levels. Compared with whites, African-American men and women are more likely to die of stroke.

**Previous heart attack or stroke or TIA -** Women who've had a heart attack are at higher risk of having a second heart attack or a stroke. Women who've had a stroke are at much higher risk of having another one or having a heart attack. A transient ischemic attack (TIA or "mini-stroke") also is a risk factor and predictor of stroke. Many risk factors can be modified, treated or controlled by focusing on lifestyle habits and taking medicine, if needed.

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**Tobacco smoke -** Smoking is the single most preventable cause of death in the United States. Women who smoke cigarettes or cigars have a much higher risk of death from heart disease or stroke. More than 145,000 women die every year from smoking-related diseases. Lung cancer has become the leading cause of cancer death among women, having increased by nearly 400 percent in the past 20 years.

**High blood cholesterol -** High blood cholesterol is a major risk factor for heart disease and indirectly increases the risk of stroke. Studies show that women's cholesterol is higher than men's from age 55 on. High levels of LDL (low-density lipoprotein) cholesterol (the "bad" cholesterol) raise the risk of heart disease and heart attack. High levels of HDL (high-density lipoprotein) cholesterol (the "good" cholesterol) lower the risk of heart disease. Research has shown that low levels of HDL cholesterol appear to be a stronger risk factor for women than for men.

**High blood pressure -** High blood pressure is a major risk factor for heart attack and the most important risk factor for stroke. Women have an increased risk of developing high blood pressure if they are 20 pounds or more over a healthy weight (for their height and build), have a family history of high blood pressure, are pregnant, take certain types of birth control pills, or have reached menopause.

**Physical inactivity -** Physical inactivity is a risk factor for heart disease and indirectly increases the risk of stroke. Overall, they found that heart disease is almost twice as likely to develop in inactive people than in those who are more active. Being overweight can lead to high blood cholesterol levels, high blood pressure, diabetes and increased risk of heart disease and stroke.

**Obesity and overweight -** Too much fat, especially in the waist area, increases the risk for health problems, including high blood pressure, high blood cholesterol, high triglycerides, diabetes, heart disease and stroke.

**Diabetes mellitus -** Compared to women of the same age without diabetes, women with diabetes have from three to seven times the risk of heart disease and heart attack and are at much greater risk of having a stroke. People with diabetes often have high blood pressure and high cholesterol and are overweight, increasing their risk even more. Diabetes also doubles the risk of a second heart attack in women but not in men.

## For additional information, contact:

American Heart Association
5 Brookside Drive
Wallingford, CT 06492-7522
203-294-0088
Fax 203-294-3577
http://women.americanheart.org

**Sources**

www.americanheart.org / Women, Heart Disease and Stroke

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# Providing Health Coverage for Uninsured Adults

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The Connecticut Women's Health Campaign supports initiatives to offer affordable, accessible health insurance coverage to uninsured adults. According to preliminary estimates from the Connecticut Office of Health Care Access based on a household survey conducted in 2001, as many as 9.3% of adults in our state were continuously uninsured or lacked health insurance during some time that year. Of those who were uninsured, approximately half were women and half were men.[1] Based on 2000 U.S. Census population estimates, we can estimate that there are approximately 242,000 uninsured adults in Connecticut.

We know from previous OHCA data that a majority of uninsured adults are employed. Nevertheless, these uninsured adults are either not offered or cannot afford health insurance offered by their employers. The lack of adequate health insurance prevents people from obtaining routine medical care, screening and preventive care which leads, in turn, to more dangerous and acute medical problems. The lack of adequate health insurance is costly to everyone – in poor health for those who cannot obtain regular care, and in greater uncompensated emergency and hospital costs for all of us.

## What Can Be Done?

- Expand HUSKY A to provide coverage to individual parents with household incomes up to 185% of poverty and expand HUSKY B to provide sliding scale insurance to parents with household incomes up to 300% of poverty.
- Allow small employers, both for-profit and non-profit, to purchase health insurance at affordable rates through group purchasing administered by the State Comptroller's office.
- Allow uninsured employees of non-profit organizations receiving funding through the State of Connecticut to purchase health insurance through the state employee health plan.

## Information About Uninsured Adults

According to the Office of Health Care Access, there were approximately 242,000 uninsured adults in Connecticut in the late 90's – essentially the same number as today. As many as 80% of those who are uninsured had household incomes under 300% of the federal poverty level.[2]

The Permanent Commission on the Status of Women conducted a study entitled *Connecticut Women's Voices 2000,* and found overwhelming support, across gender and political party lines, for state involvement in providing health insurance. Of those surveyed: 82% of women, 73% of men, 88% of Democrats and 69% of Republicans believed that the state should do more to help uninsured individuals get affordable coverage.[3] Research published in the Journal of the American Medical Association documented the

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health consequences experienced by adults without insurance. Nearly half of those without insurance for over a year had not received a routine physical in the previous two years, as opposed to 17.8% of insured adults. Uninsured adults with risk factors such as smoking, diabetes, high cholesterol levels, those with hypertension or HIV infection were even less likely to have seen a doctor. Long term uninsured adults were less likely to have received cancer screens, cardiovascular risk reduction, or diabetes care.[4]

For data close to home, we can look to a project the PCSW sponsored with Yale Medical School graduate students who conducted focus groups with women who were uninsured to learn how they manage their personal health care needs in the absence of health insurance coverage. The women they studied worked an average of 31 hours per week and earned between $20,000 and $29,999 per year. The women reported that they would postpone seeking medical care until they judged that their conditions absolutely warranted professional attention. For those with conditions needing prescription medications, they often did without or reduced the dosage to make it last longer.

National research also consistently shows that coverage that includes the whole family increases enrollment for children. For example, the Center on Budget and Policy Priorities found that states with expansions that included parents experienced a 16 percent increase in child participation from 1990-98 while states that did not include parents had only a 3 percent increase.[5] One of the obvious advantages to expanding coverage for adults in Connecticut would be to create a more standard and easily understood program of coverage, rather than the current situation in which parents are eligible for coverage if the household income is below 150% of poverty, but their children are eligible up to 185% or 300% of poverty for HUSKY A or B respectively. The current situation is a recipe for confusion.

## For more information, contact:

Connecticut Office of Health Care Access
410 Capitol Avenue
MS #13HCA
PO Box 340308
Hartford, CT 06134-0308
860-418-7001
800-797-9688
www.ohca.state.ct.us

Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Foundation
1450 G. Street NW, suite 250
Washington, DC 20005
202-347-5270
www.kff.org

Permanent Commission on the Status of Women
18-20 Trinity Street
Hartford, CT 06106
860-240-8300
www.cga.state.ct.us/PCSW

Health Care for All Coalition
139 Vanderbilt Avenue
Hartford, CT 06110
860-947-2200

### Endnotes

[1] State of Connecticut Office of Health Care Access, preliminary data from 2001 Household Survey, personal communication
[2] State of Connecticut Office of Health Care Access, April, 1998.
[3] *Connecticut Women's Voices 2000*, Center for Policy Alternatives, Lifetime Television, and the Connecticut Permanent Commission on the Status of Women (quoted charts attached to testimony).
[4] J. Ayanian, et. al. *Journal of the American Medical Association*, Oct, 25, 2000, http://jama.ama-assn.org as cited in the CT Health Policy Newsletter, Ellen Andrews
[5] Broadus, Matthew, Ku, Leighton. "The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms," Available at www.cbpp.org. From Fact Sheet published by the CT Children's Health Council

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# Restoration of All Medical Transportation for SAGA Recipients

The Connecticut Women's Health Campaign and the CT AIDS Residence Coalition (CARC) support the restoration of non-emergency medical transportation to people receiving State Administered General Assistance (SAGA). CARC is a coalition of twenty-six AIDS housing programs located throughout the state. The Connecticut Women's Health Campaign has identified this as a priority issue because it is a vital service to people with HIV / AIDS, and our state has a very high rate of HIV infection among women compared to the country as a whole.

## The Problem

When the non-emergency medical transportation service was cut from the state budget it left many people without a service that makes a crucial difference in their ability to stay safe, healthy and productive. Prior to the budget cut, non-emergency medical transportation was provided to extremely poor and medically compromised individuals. The vast majority of people receiving SAGA benefits receive medical benefits only, leaving no cash to even consider taking a bus or offering a friend reimbursement for gas.

Many people receiving SAGA medical benefits have complex medical and social issues. For example, a person may be in recovery for HIV / AIDS along with battling a mental illness. Loss of medical transportation adds immensely to the problems of the individual. Alternative means of transportation become central as the person tries to get to the methadone clinic, medical appointments, counseling and treatment for mental illness, or the blood lab, all of which are essential for the person's well-being. If a person cannot get to the methadone clinic his or her recovery is jeopardized. The inability to keep regular medical appointments can lead to missed diagnoses and greater chance for developing life-threatening infections. Regular blood work, which allows a primary caregiver to carefully monitor progress and make necessary, frequent changes to medications is as indispensable as mental health treatment.

## What Can Be Done?

Over the years the AIDS population in Connecticut has changed. Many people living with AIDS in the state have multiple diagnoses; HIV / AIDS, substance use, and mental illness are commonly linked together. Connecticut's AIDS housing programs shelter people that come directly from prison, substance use centers, and mental health facilities, making up approximately thirty percent of the housing population. Additionally, in 2000 the statistics for reported HIV / AIDS cases show three notable differences between the state and the nation. Females make up 37.7% of all cases in Connecticut compared to 24.3% in the U.S.; Latinos make up 32.2% of all cases in Connecticut versus 18.8% in the

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U.S.; and injecting drug users make up 41% of all cases in Connecticut compared to 21.6% nationally.[1] The need for medical transportation services for SAGA recipients in Connecticut is undeniable.

Many SAGA recipients have long histories of homelessness, institutionalization, and incarceration. They are the poorest of the poor. Personal barriers, lack of availability and access to substantial time in treatment, and the lack of affordable housing means they will need more services in order to meet their complex needs, certainly not less.

## For additional information, contact:

Connecticut Aids Residence Coalition
56 Arbor Street
Hartford, CT 06106
860-231-8212
www.ctaidshousing.org

Department of Public Health
401 Capitol Avenue
Hartford, CT 06134-0308
860-509-8000
www.dph.state.ct.us.

### Endnotes

[1] Department of Public Health. Surveillance Report. December 2000, Hartford, Connecticut.

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# Access To Affordable Medications

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The Connecticut Women's Health Campaign supports measures that provide for increased access to affordable medications. No person should be denied appropriate medications for financial reasons.

## The Problem

Our state and nation are facing a mounting crisis surrounding the growing inability of our citizens to gain access to medications at affordable prices. More than 500,000 state residents have no coverage for prescriptions, and those with coverage are seeing attempts to cut their benefits or impose greater restrictions.

A tension between imposing greater regulation of pharmaceutical companies versus greater restrictions or cuts to consumers, pharmacies, businesses and the state has become a major factor in public and private budget discussions. The cost of prescriptions has become an issue not only for uninsured consumers, but also for patients with private insurance, as well as people enrolled in Medicare, Medicaid, HUSKY and other state health programs.

U.S. pharmaceutical spending per person is the fourth highest in the world, according to the Pharmaceutical Research and Manufacturers of America. The prices paid for prescription drugs in the United States are the highest in the world. Spending for prescription drugs has increased at a much faster rate than overall spending for total health care. Part of this increase can be attributed to new therapies. In the field of arthritis, for example, there have been 10 new drugs and 4 new categories of drugs approved since 1997.[1]

Research has produced an avalanche of these newer, more effective, safer medications and biologic agents that offer great promise to people with chronic illness and to our aging society. However, these therapies represent the fastest rising segment of expenses for a health care system that is sensitive to cost pressures. The response of this system has been to institute or propose a variety of measures to resist higher costs by limiting consumer access to a full range of prescription medications and other cost-cutting measures.

For example, the proposed 2002-03 State Budget contains reductions in pharmacy dispensing fees for Medicaid. It limits the ConnPACE state drug assistance program by imposing asset tests on consumers. It requires prior authorization for many prescription drugs used in the Medicaid program by very low-income elderly and disabled enrollees, and more. And overall, the state budget has been cut back in other, non-health-related areas due to rising costs of pharmaceuticals.

Women will be more directly affected by such cuts. The majority of minimum wage and part-time workers are women, and these are two populations that lack adequate coverage for medications. In addition, more seniors are women and must pay for medications out of

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their own pocket because there is no national medication benefit in Medicare. Managed care programs for seniors with medication benefits have dropped out of the marketplace in the state, leaving seniors few options for affordable prescription drug coverage. This is particularly alarming in light of the fact that the average woman over the age of 65 takes as many as seven different medications.

## What needs to be done?

CWHC supports the following measures, whether through legislation or regulatory change, to increase coverage and access to affordable medications.

### Coverage

- Support adequate prescription drug coverage for all individuals enrolled in private health insurance plans.
- Provide access to the state health programs that include prescription drug coverage, including the HUSKY program for adults, as well as to health plans administered by the State Comptroller responsible for municipal and state employee benefits, to assist especially the unemployed, underemployed and part-time and lower income workers.

### Access and Pricing

- Lower the cost of prescription medications by looking at bulk-purchasing initiatives and providing state Medicaid discounts to consumers through a state discount card and other programs.
- Establish a state prescription affordability oversight board, to review and suggest strategies for decreasing prices, including proven programs for providers and pharmacists, such as state counter-detailing education programs which can provide alternate sources of prescribing information.
- Insure that the choice of the best and safest medication is made by the physician and patient, rather than a third-party interested in controlling costs, such is the case with most prior authorization plans directed by HMOs or state government.
- Oppose any plans to implement existing prior authorization state laws that do not contain strong consumer protections and a clear system of consumer input, oversight and feedback.
- Consider disease or case management approaches for total cost-savings, to avoid unnecessary hospitalizations and other problems by encouraging appropriate use of medicines. In 1997, such a CIGNA HMO program resulted in a 23% reduction in hospital admissions and a 15% improvement in appropriate medicine use.[2]

## For additional information, contact:

Health Care For All Coalition
Connecticut Citizen Action Group
139 Vanderbilt Avenue
West Hartford, CT 06110
860-947-2200
Fax 860-947-2222
ccag@ccag.net

## Endnotes

[1] Arthritis Foundation, *Arthritis Today* Drug Guide Jan-Feb 2002
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# CONNECTICUT WOMEN'S HEALTH CAMPAIGN

**c/o Permanent Commission on the Status of Women**
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw


# Services for Victims of Violent Crime in Connecticut

**The Connecticut Women's Health Campaign**

American Cancer Society
American Heart Association
Carey Consulting
Child Health Data Center
CT Association for Human Services
CT Breast Cancer Coalition
CT Chapter of American College of Nurse-Midwives
CT Citizens' Action Group
CT Coalition Against Domestic Violence
CT Coalition for Choice
CT Community Care, Inc.
CT NARAL
CT NOW
CT Sexual Assault Crisis Services
CT Women's Consortium
CT Women and Disability Network
Department of Nursing Quinnipiac University
Dept. of Services for Persons with Disabilities, City of New Haven
Hartford College for Women
National Council of Jewish Women
Latino and Puerto Rican Affairs Commission
National Ovarian Cancer Coalition-CT
Older Women's League of NWCT
Permanent Commission on the Status of Women
Planned Parenthood of CT
UCONN School of Allied Health
UCONN Asian American Studies Institute
UCONN Women's Center
Yale School of Medicine/ Department of Epidemiology & Public Health

The Connecticut Women's Health Campaign supports improving the services for and response to victims of violent crime in Connecticut. Appropriate response and services for victims of violent crime can help victims heal and reduce the risk of mental and physical health problems.

## The Problem

Crime victims who seek out support, assistance, and information about their rights, generally go to those most familiar to them rather than turn directly to the criminal justice or health care systems. A recent study completed by Macro International[1] to examine services accessed by sexual assault victims indicates that sexual assault victims in particular will turn to a friend, family member, colleague, faith community leader, doctor, hairdresser, or other acquaintance before they go to the police, hospital or other professional.

The majority of Connecticut's citizens, however, are not prepared nor equipped to give victims the information they need about their rights and services, therefore leaving a large service and resource delivery gap for victims of crime in Connecticut.

## What can be done?

Victims of crime need to receive timely information about their constitutional rights and have access to informed and competent services and service delivery systems. Statewide, community based, collaborative programs are needed to meet the needs of crime victims. When citizens are educated about a crime victim's responses and knowledgeable about necessary resources and support, they can then serve as competent first responders for victims.

The Connecticut Women's Health Campaign supports an Act Concerning Access to Services for Victims of Crime, which would provide $300,000 for a collaborative effort between the State of Connecticut Office of Victims Services and organizations that work with, and on behalf of, victims of violent crime. The Act Concerning Access to Services for Victims of Crime would create:

- A statewide public awareness campaign to educate, inform, and identify resources for the general public about crime victim's rights and services.
- Specific outreach efforts by Connecticut Sexual Assault Crisis Services, Connecticut Coalition Against Domestic Violence, Mothers Against Drunk Driving, and Survivors of Homicide to promote community safety through education and information about services and rights to members of the general public and crime.

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## Who are the crime victims?

Within the next hour at the current rate of crime in the United States, 2 people will be murdered, 78 women will be raped, 240 women will be battered, 84 individuals will be stalked, and 360 children will be abused or neglected.

Over 41,000 victims of crime in Connecticut were provided services this past year through community based service providers including 200 victims of drunk driving accidents, 36,281 domestic violence victims, 4,554 sexual assault victims and their family members, and 107 survivors of homicide.[2]

Victim service providers struggle to meet the rising needs of domestic violence, sexual assault, drunk driving, and homicide victims and survivors due to lack of resources and funding.

A study of one HMO found that women with a history of sexual abuse have significantly higher primary care and outpatient costs than women without a similar history. Annual costs of the increase to this HMO totaled over 7 million dollars.[3]

Medical expenses from domestic violence are estimated to total at least $150 million annually.[4]

## For additional information, contact:

Connecticut Sexual Assault Crisis Services, Inc.
96 Pitkin Street
East Hartford, CT 06108
860-282-9881
HOTLINE: 1-888-999-5545

Connecticut Coalition Against Domestic Violence
100 Pitkin Street
East Hartford, CT 06108
860- 282-7899
HOTLINE: 1-888-774-2900

### Endnotes

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# Continuation of State Assistance to Legal Immigrants



The Connecticut Women's Health Campaign supports access to health benefits for all legal immigrants, including women and their families. Despite their contributions to the economy and the diversity of the US, immigrants disproportionately lack health insurance, particularly low-income immigrants, who are twice as likely to be uninsured as low-income citizens. Under the federal welfare reform legislation (Personal Responsibility and Work Opportunity Reconciliation Act of 1996; Balanced Budget Acts of 1997, 1998), immigrants who entered the country after August 22, 1996 are no longer eligible for federal benefits under the Temporary Assistance to Families (TFA) and Medicaid programs for a period of five years after entering the United States.

Recognizing the hardship that welfare reform legislation would bring to legal immigrants, their families and supporters, the State of Connecticut initiated state-funded TFA, medical assistance and SAGA (State-Administered General Assistance) programs for legal immigrants who entered the country after August 22, 1996. Immigrants receiving these benefits are required to pursue citizenship to the extent possible, unless medical or language barriers preclude this. The law authorizing these state–funded programs expires on June 30, 2002.

## What needs to be done?

The state-funded TFA, SAGA and medical assistance programs for legal immigrants should be reauthorized in the 2002 legislative session.

## Why should state-funded TFA, medical assistance and SAGA be continued?

Ultimately, all residents of Connecticut benefit from supporting legal immigrants in being healthy, productive members of society. These programs constitute a wise investment in future citizens of the state as well as their children, who may themselves be citizens. They provide basic support within existing systems to persons residing legally in the state. If support is not provided through these programs, the responsibility for this support will fall on emergency support systems, including hospital emergency rooms, often at greater cost to taxpayers.

## Who benefits from these programs?

These programs are designed to provide access to basic medical care and limited cash assistance to people who entered the country legally, as they join the workforce and transition to citizenship. Most immigrants (72%) reside in the US legally (the majority

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have entered via family reunification). The remaining 28% are undocumented immigrants, most of whom entered legally (e.g., students, tourists, business) but stayed beyond the expiration of their visas.[1] Seven and a half percent of Connecticut's population is foreign-born, ranking the state 15th with respect to immigration among the fifty states.[2]

Welfare reform was associated with drastic declines in Medicaid participation among immigrants (17% to 9% over the years 1994-1998),[3-6] and generated substantial fear that receiving Medicaid could jeopardize immigration status for even those persons who are eligible.[7] Continuing eligibility for benefits after the five-year ban is determined at the state level, leading to variability in benefits across the country.

As a result, absence of a usual source of health care is far more prevalent among low-income immigrant adults (37%) as compared to low-income native citizens (19%).[6] Moreover, one in five children residing in the US, roughly 14 million, is an immigrant or born to one or more immigrant parents.[8] Non-citizen children average under half as many provider visits annually than their counterparts in citizen families (1.5 vs. 3.7 visits).[6] Three-fourths of children within immigrant families were born in this country, yet even they do not receive entitlements for which they are eligible as native citizens because of their parents' concerns about jeopardizing their own immigration status.

## For additional information, contact:

Connecticut Conference for the United Church of Christ
125 Sherman St
Hartford, CT 06105
860-367-8288
www.ctconfucc.org

Legal Services of Connecticut
62 Washington St
Middletown, CT 06457
860-344-0447
www.connlegalservices.org

Center for Children's Advocacy
UConn School of Law
65 Elizabeth St
Hartford, CT 06105

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7 Schlosberg C, Wiley D. (1998). "The Impact of INS Public Charge Determinations on Immigrant Access to Health Care." National Health Law Program and National Immigration Law Center, May. (www.healthlaw.org/publications.shtml#immig)
8 Hernandez DJ, Charney E (eds.). From Generation to Generation: The Health and Well-being of Children in Immigrant Families. Washington, D.C.: National Academy Press, 1998.

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**c/o Permanent Commission on the Status of Women**
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Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw




# The Myth about the Link Between Abortion and Breast Cancer

The Connecticut Women's Health Campaign supports a woman's right to choose safe and legal abortion and her right to access to complete and accurate information about reproductive health care.

## The Problem

Some anti-choice groups have been using unethical scare tactics by publicizing an unsubstantiated link between abortions and an increased risk of breast cancer. However, the results of two recent case-control studies, two large cohort studies, and two meta-analyses suggest that there is no association between safe and legal abortion and risk of breast cancer.[1]

Several past case-control studies have suggested that both spontaneous and induced abortions may be associated with small increases in the risk of breast cancer.[2] However, these case-control studies have been criticized due to their potential for reporting bias; women who have breast cancer may be more likely to give accurate reports of their abortion histories than women who do not have breast cancer because of the incentive they have to give their treating physician their complete medical history.[3] One of the more recent cohort studies[4] avoided the problem of reporting bias by relying on data collected from registries rather than individual reports. This study found no association between abortion and breast cancer risk.

## What Can Be Done?

In general, the causes of breast cancer are poorly understood.[5] Two studies have found a transient increase in the risk of breast cancer following full-term pregnancy.[6] The effects of abortion on breast cancer risk may be similar to those of full-term pregnancy, i.e. they may be transient and weaken with age. In addition, some evidence suggests that later abortions (after the first 12 weeks of gestation) may be associated with an extremely slight increased risk of breast cancer.[7] However, the risk identified in these studies is so slight that it is equal to or less than the increased breast cancer risk associated with marital status, place of residence, or religion.[8] In other words, it is not medically meaningful. There is more we need to learn about the hormonal effects of pregnancy and abortion on breast cancer risk. More epidemiological studies, particularly prospective studies that consider effect modification by gestational age at abortion, are needed before further conclusions can be drawn.[9]

Despite the absence of medical proof, abortion opponents are using media campaigns, legislation, and litigation to frighten women into believing that abortion causes breast cancer. Their attempts to distort scientific findings and medical facts around the

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breast cancer issue are part of a broader campaign by anti-choice forces to stigmatize abortion. In addition, anti-choice forces are seeking to enact state laws requiring doctors to warn women of links between abortion and breast cancer that are unsubstantiated by scientific research. An editorial in the *Journal of the American Medical Association* calls these legislative efforts premature and suggests that the misuse of science by those seeking to outlaw abortion could hinder scientific research in this area.[10]

Women faced with unintended pregnancy deserve scientifically accurate and unbiased information regarding their reproductive health options. Inaccurate and distorted information may deter women from exercising their constitutionally protected right to choose a safe medical procedure. Women should be informed of the controversial nature of this issue and of the results of the studies to date. Lawmakers and policy makers should support continued research into these important aspects of women's health so that proper informed decisions can be made in the future. The CWHC supports more research to answer questions regarding the medical consequences, if any, of abortions, and the causes and prevention of breast cancer.

## For additional information, contact:

CT NARAL
135 Broad Street
Hartford, CT 06105
Phone: 860-524-1086
Email: ctnaral@javanet.com
Website: www.javanet.com/~ctnaral
Website: www.naral.org

CT Breast Cancer Coalition
15 Radding Street
Manchester, CT 06040
860-649-4795

National Cancer Institute
Website: www.nci.nih.gov

American Cancer Society
P.O. Box 410
Wallingford, CT 06457
203-265-7161

**Endnotes**

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[7]Melbye M, Wohlfahrt J, Olsen JH, et al. Induced abortion and the risk of breast cancer. *N Engl J med* 1997;336(2):81-5.
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Gammon MD, Bertin JE, Terry MB. Abortion and the risk of breast cancer. Is there a believable association. *JAMA* 1996;275(4):321-2.
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Gammon MD, Bertin JE, Terry MB. Abortion and the risk of breast cancer. Is there a believable association. *JAMA* 1996;275(4):321-2.

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# Public Awareness of Anti-Choice "Crisis Pregnancy Centers"

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UCONN Asian American Studies Institute
UCONN Women's Center
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The Connecticut Women's Health Campaign supports the access of women to the full range of reproductive health care services and the protection of a woman's right to choose. To achieve this goal, women must be assured of receiving accurate medical information and legitimate services. The CWHC does not support the misleading anti-choice practices of Crisis Pregnancy Centers. CPCs target women faced with unintended pregnancies, especially young and low-income women who are most vulnerable, to dissuade them from exercising their constitutional right to choose legal abortion.

## The Problem

CPCs offer services such as free pregnancy tests and options counseling, among others, but their deceptive advertising conceals their anti-abortion agenda. Some centers also resort to evasions and lies to attract women into their facilities. Women who go to CPCs seeking information on all reproductive options are faced instead with deception, misinformation, and scare tactics designed to dissuade them from having an abortion.

One tactic of CPCs includes showing sensationalized videos and slide show images while women wait for the results of a pregnancy test. Frightened and confused women are also subjected to coercive or high-pressure anti-abortion sermons. Some CPC volunteers have even made exaggerated promises of financial assistance if a woman chooses to go through with an unintended pregnancy.

These Crisis Pregnancy Centers are usually not licensed medical clinics, but tend to portray themselves as such through the appearance of the facility, the dissemination of so-called medical facts on procedures such as abortion, and the center volunteers' "counseling" techniques. The fake "clinics" also locate themselves near legitimate women's health care clinics that provide abortions, and call themselves by neutral or feminist names that further mislead women into thinking they will receive complete and reliable information at the centers.

## What Can be Done?

Regardless of their views on abortion, most health care professionals agree that women have the right to full, accurate, and unbiased information about their reproductive health options, and that this information should be provided in a non-coercive environment. The public needs to be educated as to the existence of Crisis Pregnancy Centers, their deceptive advertising, their covert anti-choice agenda, and their false information. More

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research needs to be done on the subject of CPCs before further legislative or legal action can be taken. Increased efforts are also needed to promote and advertise legitimate women's health care clinics as well so that women facing the difficult situation of an unintended pregnancy know where they can go to receive comprehensive and factual information, counseling, and referrals on a full range of reproductive options.

- There are now over 3000 CPCs across the country, as compared to only 2000 abortion providers.[1]
- The New York Attorney General's office recently (as of January 2002) issued another subpoena to a Crisis Pregnancy Center as part of an investigation into whether such centers give out medical advice without proper licensure or "misrepresent their services" to pregnant women.[2]

## For additional information, contact:

CT NARAL
135 Broad Street
Hartford, CT 06105
860-524-1086
ctnaral@javanet.com
Website: www.javanet.com/~ctnaral

National Abortion and Reproductive Rights Action League
Website: www.naral.org

### Endnotes

[1] Stanley K. Henshaw, *Abortion Incidence and Services in the United States*, Family Planning Perspective, 254, 267 (Nov./Dec. 1998).
[2] Jason Pierce, "Another Subpoena Issued to NY Crisis Pregnancy Center," 01/09/02, CNSNews.com.

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Yale School of Medicine/ Department of Epidemiology & Public Health

# Ovarian Cancer: Myths and Facts

The Connecticut Women's Health Campaign (CWHC) supports public education about ovarian cancer, the deadliest gynecological malignancy and the fifth leading cause of cancer death among women in the United States. Ovarian cancer kills more women each year than cervical and endometrial cancers combined. It has claimed the lives of Connecticut residents including Ella Grasso, the first female Governor of Connecticut; Laura Nyro, singer-songwriter; and Gilda Radner, comedienne. The CWHC is committed to raising awareness and promoting education regarding ovarian cancer in the state of Connecticut. Our goal is to save women's lives through early detection of this furtive killer.

In June, 2001, the first legislative action to decrease the impact of ovarian cancer on women in Connecticut was supported by the Connecticut General Assembly. The legislation (Public Act 01-4-House Bill 7505) allotted $25,000 for the development of a brochure by the Connecticut Department of Public Health that provides educational information to consumers, patients and health care providers regarding gynecologic cancers.

## What can be done?

The statewide ovarian cancer education program must be continued and expanded. Recent legislation in Connecticut supports an early detection program for breast and cervical cancer for underinsured women; ovarian cancer and other gynecological cancers should be included in this legislation. Other states have passed legislation requiring physicians to provide information about the availability of surveillance tests for ovarian cancer to high-risk patients during an annual examination. Diagnostic procedures should include but not be limited to a CA 125 blood test, transvaginal sonography or any other technology proven to detect ovarian cancer as it becomes available. Other states have also enacted legislation requiring health benefit policy coverage for surveillance tests for women at risk for ovarian cancer.

Myths about ovarian cancer must be dispelled in order to reduce the deaths that result from this disease. Ovarian cancer is not rare. The lifetime risk of this disease for women worldwide is 1 in 70. In the United States, the risk is 1 in 55. The risk for ovarian cancer increases as a woman's age increases. In fact, at age 60, a woman's risk of developing any cancer rises from 1 in 11 to 1 in 5. Ovarian cancer, however, is not a disease of older women. It can occur as young as the teen years. According to the American Cancer Society, it is estimated that more than 23,000 women of all ages will be diagnosed with ovarian cancer in 2002.

Ovarian cancer is one of the deadliest diagnoses a woman can receive - an estimated 14,000 women died from the disease in 2002. Currently, 50% of women diagnosed with advanced ovarian cancer die from the disease within five years. African-American

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women have lower disease rates than Caucasian, Hispanic, Asian or Pacific Islander women; however, their death rates are higher due to poorer access to a timely diagnosis and medical care.

Ovarian cancer is often referred to as a "silent killer" because of the stealth with which the illness advances. This is because ovarian cancer occurs in an organ deep within the pelvis, producing symptoms that are nonspecific and easily dismissed in the earliest stages of the disease. However, contrary to common belief, ovarian cancer is not silent. Currently, more than 90% of women who are diagnosed with Stage I ovarian cancer came to their doctors with symptoms prior to diagnosis. If the disease is detected in Stage I, when it is confined to the ovary, there is a 90% cure rate. Unfortunately, only 25% of ovarian cancer cases are now diagnosed at an early stage. Clearly, early detection of ovarian carcinoma gives a woman nearly four times greater chance of survival. Many women believe that the Pap Test, which detects cervical cancer, also detects ovarian cancer, but the Pap Test does not detect ovarian cancer. At this time there is not a reliable early screening measure for ovarian cancer. In order to save women's lives, therefore, women must receive current educational information regarding risk factors, prevention and early identification of the symptoms associated with ovarian cancer.

## What are the risk factors?

Risk factors include:

- personal or family history of breast, ovarian, endometrial, prostate, or colon cancer;
- hereditary nonpolyposis colorectal cancer (HNPCC) or Lynch syndrome;
- increasing age;
- unexplained infertility, no pregnancies or history of birth control usage;
- use of high-dose estrogen for long periods without progesterone;
- North American or Northern European heritage and / or Ashkenazi Jewish descent;
- living in an industrialized country.

## What are the symptoms?

Persistent symptoms of ovarian cancer may include:

- abdominal pressure, bloating and / or pain;
- vague but persistent gastrointestinal problems;
- excessive fatigue;
- back pain;
- low grade fever;
- frequent or urgent urination;
- menstrual disorders;
- pain during intercourse;
- weight gain or loss.

Although ovarian cancer physically affects only women, the toll on sons, husbands and fathers is enormous. Ovarian cancer robs families of their mothers, wives, sisters, and daughters, often after years of debilitating illness with tremendous emotional and financial cost. Early detection of ovarian cancer, when a cure is possible, would alleviate the emotional and economic burden that many families in Connecticut experience.

## For additional information, contact:

National Ovarian Cancer Coalition-Connecticut (NOCC-CT)
203-315-8151
CT.NOCC@ovarian.org

### Endnotes

Piver, S.M., Eltabbakh,G (2000). *Myths and Facts About Ovarian Cancer*. New York: PRR
National Ovarian Cancer Coalition www.ovarian.org
Ovarian Cancer National Alliance www.ovariancancer.org
The National Cancer Institute www.cancer.gov/cancer_information
American Cancer Society www.cancer.org

### Additional Selected Resources:

Gynecologic Cancer Foundation, www.sgo.com
Women's Cancer Network www.wcn.org
Ovarian Cancer Research Fund, www.ocrf.org
Cancer Care, www.cancercare.org.
Oncolink, www.oncolink.upenn.edu.

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Yale School of Medicine/ Department of Epidemiology & Public Health

# Increasing Breastfeeding Rates

The Connecticut Women's Health Campaign supports efforts to increase the rates of breastfeeding and the duration of breastfeeding in Connecticut, as well as to eliminate the racial and ethnic disparities that exist in breastfeeding rates. As the Surgeon General states, "Breastfeeding is one of the most important contributors to infant health. Breastfeeding provides a range of benefits for the infant's growth, immunity, and development. In addition, breastfeeding improves maternal health and contributes economic benefits to the family, health care system, and workplace." [1]

However, even though breastfeeding is associated with all of these positive outcomes, breastfeeding rates remain low, especially at 6 months post-partum and among minority groups. While recent Connecticut legislation protects a women's right to breastfeed in the workplace (PA No. 01-182), there still remains a large public health need to improve support for breastfeeding in the family, the community and the health care system.

The goals regarding breastfeeding as stated in Healthy People 2010 are to increase to 75% the proportion of mothers who breastfeed in the early post-partum period, to increase to 50% the proportion of mothers who breastfeed through 5-6 months of age, and to have 25% of mothers breastfeed to the end of 1 year. In addition, one of the major goals of Healthy People 2010 is to eliminate health disparities among different segments of the population, which applies to breastfeeding.

## What Can be Done?

In order to achieve these public health goals in Connecticut, there needs to be an increased commitment to the following:

- Educate all health care providers and payers regarding appropriate breastfeeding and lactation support.
- Mandate that third party health care payers and Medicaid Managed Care Organizations adequately reimburse for lactation and breastfeeding services and medically advised equipment.
- Develop and implement a comprehensive statewide marketing program that portrays breastfeeding as normal and achievable.
- Create programs to increase protection, promotion, and support for breastfeeding mothers in the workforce.
- Develop an educational curriculum for grades K-12 portraying breastfeeding as the normal and preferred method of feeding babies.
- Increase funding for clinical, epidemiological, programmatic, and other research on breastfeeding and human lactation.
- Develop a statewide database documenting rates of breastfeeding initiation and duration.

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- Develop community-based support for breastfeeding, including peer counseling, hot-lines, and support groups.

**Breastfeeding benefits children, mothers, employers, and the healthcare system.** Breastfeeding has many health benefits for children, even premature infants. Human milk contains anti-inflammatory factors and other factors that regulate the response of the immune system against infection.[2] This reduces the risk for many illnesses in babies, such as ear infections (otitis media), upper and lower respiratory infections, urinary tract infections, and diarrhea. It also reduces the risk for several chronic diseases, including diabetes, childhood leukemia, celiac disease, and allergic disease / asthma. In addition, breastfeeding reduces the risk of obesity and Sudden Infant Death Syndrome, enhances brain and IQ development, and enhances strong jaw and facial development. Studies suggest that the benefits continue after breastfeeding ceases.[2]

**Breastfeeding also benefits the mother.** It decreases postpartum bleeding, decreases the risk of anemia, helps in weight reduction, and reduces the risk of breast cancer, osteoporosis, and endometrial cancer. Mothers that breastfeed their children may also experience psychological benefits, such as increased self-confidence and facilitated bonding with their infants.[2]

**Breastfeeding benefits employers** by producing less employee turnover, faster return from maternity leave, less maternal absenteeism, and happier employees. Moreover, employer medical costs are lower and employee productivity is higher.

**Breastfeeding saves money.** Breastfed children typically require fewer sick care visits, prescriptions, and hospitalizations. As a result, total medical expenditures are about 20% lower for fully breastfed infants than for never-breastfed infants.[2] "In the U.S., the health care system would save at least 2-4 billion dollars annually if mothers were enabled to choose and to succeed in breastfeeding for as little as twelve weeks," says Marion Labbock, M.D., Medical Researcher at Georgetown University. In addition, families can save several hundred dollars over the cost of feeding breast milk substitutes.[2]

## For additional information, contact:

La Leche League of Connecticut
1-860-563-6624
www.lalecheleague.org

Dial Infoline at 211

U.S. Department of Health and Human Services
Office on Women's Health
1-800-994-9662
TDD 1-888-220-5446
www.4women.gov

**Endnotes**

[1] David Satcher, M.D., Ph.D., Assistant Secretary for Health and Surgeon General, U.S. Department of Health and Human Services.
[2] HHS Blueprint for Action on Breastfeeding, U.S. Department of Health and Human Services Office on Women's Health, Washington, D.C., 2000.

# CONNECTICUT WOMEN'S HEALTH CAMPAIGN

**c/o Permanent Commission on the Status of Women**
18-20 Trinity Street Hartford, CT 06106
Phone: (860) 240-8300 E-mail: pcsw@po.state.ct.us
Fax: (860) 240-8314 Website: www.cga.state.ct.us/pcsw


**The Connecticut Women's Health Campaign**

American Cancer Society
American Heart Association
Carey Consulting
Child Health Data Center
CT Association for Human Services
CT Breast Cancer Coalition
CT Chapter of American College of Nurse-Midwives
CT Citizens' Action Group
CT Coalition Against Domestic Violence
CT Coalition for Choice
CT Community Care, Inc.
CT NARAL
CT NOW
CT Sexual Assault Crisis Services
CT Women's Consortium
CT Women and Disability Network
Department of Nursing Quinnipiac University
Dept. of Services for Persons with Disabilities, City of New Haven
Hartford College for Women
National Council of Jewish Women
Latino and Puerto Rican Affairs Commission
National Ovarian Cancer Coalition-CT
Older Women's League of NWCT
Permanent Commission on the Status of Women
Planned Parenthood of CT
UCONN School of Allied Health
UCONN Asian American Studies Institute
UCONN Women's Center
Yale School of Medicine/ Department of Epidemiology & Public Health

# Accessible Community Health Care for Women

The Connecticut Women's Health Campaign supports increasing access to quality community health care for older women and women with disabilities to prevent unnecessary or premature institutionalization.

Today's older adult women face many obstacles to receiving health care that helps them remain in their homes and communities. A primary factor is the inability to afford home care services that would allow them to delay nursing home placement and stay in their community. On average, retired women's pensions are less than half that of the average male and they often receive a Social Security benefit that is less than one-third of the average male. Many women also lack a pension benefit and must rely solely on their Social Security income.

Women traditionally have also been the caregivers in our society, forcing them to leave the workforce for long periods to care for family members. In general, over a lifetime, women earn less in wages than men, leaving many women impoverished in their retirement years. According to the 1990 Census, 78% of the elderly in poverty in Connecticut were women. The State of Connecticut should be taking a proactive role in providing comprehensive home and community-based services for Connecticut's elder women that optimize quality of care.

## Proposed Solutions

### Funding for CT Home Care Program for Elders

We recommend that the Connecticut Home Care Program for Elders (CHCP) be fully funded to reflect the growing need for home care services. During the November Special Session the CHCP's state funding budget was reduced by $5 million dollars and replaced with Social Services Block Grant (SSBG) Funds that have historically been targeted for cuts. This budgetary jockeying leaves the CHCP Program vulnerable.

### Pre-Admission Screening

Pre-admission screenings should be mandated before anyone enters a nursing home, regardless of their income. Presently, only people who are Medicaid-eligible are screened by the staff of DSS (CHCP) prior to entering a nursing home. This screening process gives people information about options to institutionalized care. This initiative offers long-term cost savings by reducing the cost of long term care for individuals who would forgo entering a nursing home by qualifying for services under the Connecticut Home Care Program.

### Improve Staff Recruitment, Education Compensation and Retention

According to the State of Connecticut – Long Term Care Plan (January '01), staffing shortages were the most pressing long term care issue facing the state. These shortages exist

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across the long term care spectrum. During public hearing forums sponsored by the State Long Term Care Planning Committee, many groups stated that it has become more and more difficult to recruit, train, and retain staff and that lack of home care staff has resulted in individuals being prematurely placed in nursing homes. The CWHC supports legislative initiatives being introduced through the Long Term Care Advisory Council to address this problem.

## For additional information, contact:

Connecticut Community Care, Inc.
43 Enterprise Drive
Bristol, CT 06010-7474
860-314-2920
gaylek@ctcommunitycare.org

CT Commission on Aging
25 Sigourney Street
Hartford, CT 06106
860-424-5360
sarah.gauger@po.state.ct.us

**Endnotes**

1 Stone, R. I. & Weiner, J. M. (2001). Who Will Care for Us? *Addressing the Long-Term Care Workforce Crisis.* The Urban Institute and the American Association of Homes and Services for the Aging.
2 State Plan on Aging. (1999). State of Connecticut, Department of Social Services.
3 Business & Aging Networker. (Spring 2000). Women Uniquely at Risk in Retirement.

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# Primary Care Case Management as an Alternative to Medicaid Managed Care



Since 1995, Connecticut has provided Medicaid / HUSKY health coverage to approximately 240,000 residents, mainly children and families, through an HMO managed care system. Connecticut also offers medical assistance to very low income uninsured adults through the State Administered General Assistance Medical Program (SAGA Medical). SAGA Medical is a state-funded, fee-for-service system providing coverage for approximately 20,000 residents. Many of the enrollees in these programs are women heads-of-households and their children.

The current system of Medicaid Managed Care is plagued with problems. Recipients of Medicaid managed care have serious difficulties accessing prompt, appropriate and quality health care services. The problems are greatest in the areas of dental and behavioral health, as is reflected in the two pending class action lawsuits brought by Medicaid enrollees against the state. Fewer and fewer health care providers accept Medicaid patients because providers are inadequately reimbursed for the services they provide. Moreover, Connecticut is under the constant threat of the Medicaid managed care companies bailing out of the system. In the 2000 session, the Connecticut General Assembly passed $10.5 million in tax breaks to the Medicaid managed care companies in order to encourage them to continue participating in the Medicaid program. Ironically, the Medicaid managed care system, which was created to save money, is becoming more expensive than the fee-for-service system that it replaced.

## What Can be done?

The Connecticut Women's Health Campaign supports efforts by the state to pursue alternatives to the Medicaid managed care system that address the failings of the current system. One such alternative is Primary Care Case Management, or PCCM. In a PCCM system, Medicaid recipients either choose or are assigned to a primary care provider. This provider is responsible for managing the recipient's primary and preventive care (including locating, coordinating and monitoring health care services) and acts as a gatekeeper to specialty services. Primary care managers must provide 24-hour access to information, referral and treatment for emergencies. Primary care and other providers bill the state for the medical services they provide under a fee-for-service system. The primary care provider has a contract directly with the state outlining their responsibilities for reporting and monitoring. Primary care providers can be paid for their

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case management role in one of two ways: as a flat fee per member per month or as an increase in their service fees. In traditional PCCM models, providers bear no financial risk for the care of their assigned members.

Other states, including Massachusetts and Texas, have implemented PCCM and found it be successful. The experience from these other states shows that clients prefer PCCM to HMOs, as do providers who have more control over their practices and bear less financial risk under PCCM. States with PCCM have seen drops in ER use and inpatient hospitalizations. Member education and preventative care have improved, including smoking cessation, teen pregnancy prevention and prenatal care / education.

In the 2001 legislative session, the General Assembly passed a bill that authorized the Commissioner of the Department of Social Services (DSS) to implement a PCCM pilot program for the State Administered General Assistance (SAGA) and General Assistance (GA) recipients (Public Act 01-2, Section 20). However, funding for the pilot was cut in the first round of budget rescissions in the fall of 2001 and the program has not been implemented. It is anticipated that there will be legislation in the 2002 session mandating the Commissioner of DSS to implement PCCM for the entire Medicaid population.

## For additional information, contact:

Connecticut Health Policy Project
703 Whitney Avenue
New Haven, CT 06511
www.cthealthpolicy.org

New Haven Legal Assistance
426 State Street
New Haven, CT 06510
203-946-4811, ext. 148
SToubman@nhlegal.org

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# The Need for Trauma-Sensitive Mental Health and Addiction Services



The Connecticut Women's Health Campaign supports the delivery of behavioral health care that is sensitive and responsive to the needs of trauma survivors. Over 70,000 Connecticut adults seek care for mental health and / or substance abuse disorders each year. Most have a history of trauma, and about half struggle with post-traumatic stress disorder. Their experiences with trauma include childhood abuse or neglect, sexual assault, domestic abuse, witnessing violence or extreme human suffering.

Women suffer disproportionately from the effects of trauma. One out of every three women has been sexually abused in childhood, and women are more likely to have experienced adult sexual assault or domestic violence. At least 75% of women in substance abuse treatment programs report having been sexually abused.[1] The percentages rise dramatically for women with behavioral health issues who are incarcerated, homeless, or severely mentally ill. Women, especially parenting women, face the added burden of stigma when seeking treatment for mental illness or substance abuse. Because many service providers are not trained to recognize or treat trauma, women who seek treatment are often silenced, re-traumatized by systems of care that cannot or will not address the root cause of their problems.

## What Can be Done?

The state budget must include full funding for mental health and addiction services for adults and children.

Women and their families struggle with persistent or recurring addiction and mental health problems, yet professionals who are trained in trauma response and recovery can help stop the cycle. In the spring of 2000, The Connecticut Department of Mental Health and Addiction Services and The Connecticut Women's Consortium launched the Connecticut Trauma Initiative, a comprehensive response to the needs of trauma survivors for sensitive and supportive behavioral health care. An advisory group of providers, advocates and survivors identified the most promising trauma treatment models. Connecticut's service providers are now offered culturally competent, gender-sensitive training to understand trauma and its strong correlation to women's behavioral health. Women's recovery is in jeopardy if budget cuts in mental health and addiction services curtail the roll-out of training and services that have been so well-received by clinicians, who are also frustrated by the prevalence of trauma and the lack of trauma resources in Connecticut. Our shared crisis of September 11th brought a

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new sensitivity to the effects of trauma, and an even greater need for training and supportive services.

The impact of trauma is far-reaching and costly, resulting in medical problems, behavioral health issues, eating disorders, delinquency, learning and developmental disabilities, and family dysfunction. Survivors of trauma often cope courageously and resourcefully. Their fears, anxieties, anger and grief are real; so is their chance for recovery. It does not necessarily mean complete freedom from post-traumatic stress disorder, but many survivors live healthy and rewarding lives once they learn to manage symptoms of trauma, gain understanding and support, and renew hope and relationships.

**For additional information, contact:**

Connecticut Trauma Initiative at
The Connecticut Women's Consortium
203-498-4184 or 1-800-268-5086
www.womensconsortium.org

**Endnotes**

[1] Finkelstein, Norma (1996). Using the Relational Model as a Context for Treating Pregnant and Parenting Chemically Dependent Women. In Chemical Dependency: Women at Risk. Brenda Underhill & Dada Finnegan, eds. Binghamton, N.Y., Haworth Press, 1996.


# Connecticut Women's Health Campaign
# Statement of Principles

**1. UNIVERSAL COVERAGE** which is affordable and accessible for all people regardless of income, age employment status, immigration status or location of residence. This is especially important to women who comprise the largest group of poor people in the country and have the highest proportion of part-time workers, and especially for women of color who face additional barriers because of racism. To make the promise of universal coverage real for all women, the new health care plan must include a cap on premiums and co-pays based on a percent of income model.

**2. COMPREHENSIVE BENEFITS PACKAGE** which covers a full range of services including but not limited to reproductive health care (including contraception, prenatal care and abortion), mental health and substance abuse treatment, preventive health care (including early detection services such as mammography, PAP smears, pelvic exams, and testing for HIV and STD's), acute and long-term care, and rehabilitative care.

**3. INCLUSION OF A WIDE RANGE OF HEALTH CARE PROVIDERS AND SETTINGS**. Providers should include mid-level practitioners such as midwives and nurse-practitioners, and settings should include neighborhood health centers, family planning clinics and other programs that provide effective culturally and linguistically appropriate health care.

**4. INCREASE ATTENTION TO WOMEN'S HEALTH NEEDS IN THE NATIONAL RESEARCH AGENDA**, especially for the prevention and treatment of breast cancer and other medical conditions which disproportionately affect women, and the guaranteed inclusion of women in clinical trials and research samples for all medical conditions that affect women. Also, states should be required to collect data about women's health.

**5. EQUAL REPRESENTATION OF WOMEN AT ALL LEVELS OF DECISION-MAKING, RESEARCH AND SERVICES DELIVERY**, including those of different races, ages, income levels and sexual orientation. In addition, health care consumers should be included in the decision-making process.

**6. CONFIDENTIALITY WHICH IS ESSENTIAL TO PROTECT ACCESS** for all people including, but not limited to minors, people with HIV infection, people seeking reproductive health care, and survivors of domestic or sexual violence.



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***Working for the Health and Well Being of Connecticut Women***